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ABSTRACT

This paper reports a longitudinal study of the mental health or pathology of a non-clinical population of 45 children from 4 to 6-years-old from an environment of economic, educational and cultural advantage. Data was collected annually on these children for a period of three years. Findings showed that the majority of children between four and six years of age were judged by clinicians to have pathology, with or without interference with development, and that researchers were able to detect psychic constellations at age four that maintained themselves during the next two years. These findings point up the need to develop means for assessing mental health in the first years of life, as well as the need to explore the variety of mental health services that may be useful for children between four and six years. (AJ)

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Developmental Groupings of Pre-School Children

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In an attempt to evaluate the mental health or pathology of a non-clinical population of pre-school children, the Child Development Center, over the past eight years, has been conducting a longitudinal assessment study. Clinical methods have been employed, based on psychoanalytic developmental propositions. The children studied were grouped on the basis of their developmental progression; the reasons for assessing developmental progression were discussed in a previous paper.[1] Here we shall focus on: (1) the groupings of the children; (2) a discussion of our findings; and (3) the implications of these findings.

Beginning in the 1930's, many studies have been undertaken with nursery-school children. Most of the studies, however, have focussed on either one or a limited number of behavioral items. Usually, they have covered a short period of time, or they have been "before" or "after" measures designed to determine the effects of certain educational experiences. There have also been clinical case studies of one child, or of a small number of children, with a "disturbance" or "problem," who have been observed within a clinical setting over an extended period of time. The present study was planned as an intensive, clinical evaluation of the overall developmental progression of a larger number of children over a period of a few years.

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Our project was designed to be exploratory rather than experimental, to discover hypotheses, rather than testing them. To quote from David Bakan: "...For the fact of the matter is that good research into the unknown cannot be well-designed, in the usual sense of the term. Truly good research means that one allows the investigation to be guided by the experiences of the investigation. And this cannot be predicted. If it can be predicted, then there is little information to be obtained from the research, and considerably less reason to do the research."[2]

Three major decisions were made with regard to the design of the study: it was to be a longitudinal study; the children to be assessed were to be selected from a community nursery school; the procedure for obtaining the data was to follow a clinical model.

Longitudinal Study

We felt that, in order to investigate developmental progression, a longitudinal approach was necessary. This would encompass the process of developmental changes in each individual child, and at the same time follow the vicissitudes of each child's pathology or health. We hoped thereby to be able to identify individual patterns in development, to follow specific conflicts and symptoms, and to look at changes that took place as the children matured. We anticipated being able to detect subtle as well as gross changes in the child, to determine the rate of change, and to discover those aspects of development in which there was

stability. It was anticipated that, by studying a few given children once a year for three years, we could succeed in determining relationships between variables, such as might not be apparent from statistical analyses of differences between groups.

Subjects

We selected a community nursery school in the metropolitan area that provided a population of children comparable in age, socioeconomic status and family background to those at the Child Development Center therapeutic nursery school. Having data for these children offered the potentiality, for the future, of making comparisons between the two groups.

The children were for the most part from small families, with only one or two children. The parents were well-educated, with careers in business, the professions, or the arts. They constituted a population that was likely to be cooperative with our study requirements and which we expected would have relative geographical stability. We excluded from the study children who were mentally retarded, schizophrenic, or suffering from organic conditions, as well as those who were in psychotherapy.

Using a method of random numbers, we selected 52 children (29 boys and 23 girls) from the 94 attending the nursery school. During the three years of data-gathering, only seven children dropped out of the study (four boys and three girls), leaving us a total of 45 children for whom data had been gathered annually for three years.

At the time of the initial data-gathering, the largest proportion of children clustered around four years of age. At the first follow-up, the largest proportion clustered around five years and, at the second follow-up, around six years. Since this was a developmental study over three years, the differences in the ages of the children at the initial study were not important and did not affect the groupings.

Clinical Model of Study

For the assessment of the children, we decided to use a generally accepted clinical procedure. The data-gathering, based on propositions from psychoanalytic developmental psychology, was done by a staff that represented the usual three disciplines: psychiatry, psychology and psychiatric social work. Our sources of information included individual interviews with the children, their parents and teachers; observations of the children in the nursery-school setting; and the results obtained on a standard battery of tests. The clinician who collected the data integrated the information from the several sources and judged the child's developmental progression, once a year for three years.

Groupings

This study did not assess the children according to the usual clinical diagnostic categories; nor did it do so on the basis of symptom formation, adaptive processes, or interference in certain specific areas of psychic functioning. Instead, we used a more global approach. It was our assumption that development constitutes the major

task of childhood. This, in turn, led to our exploring the relationship of symptoms and other forms of pathology to this developmental task--namely, whether pathology inhibits or deviates further development, and if so, in what ways. The following four groups were delineated:

Group 1: Progression in development has been maintained;

Group 2: Progression in development has been maintained, but with significant accompanying pathological features;

Group 3: Progression in development has been interfered with in significant areas;

Group 4: Progression in development had been interfered with in significant areas, but is again proceeding.

Distribution of Children into Groupings

The distribution of the children for the three-year period, on the basis of the annual assessments and final review (as presented in Table 1), shows that, for each of the three years, four-fifths or more of the children were judged as belonging in either group 2 or group 3. That is, most of the children were seen as having pathology, either accompanying progression in development or interfering with development. Only one-fifth of the children were judged initially as belonging in group 1, fewer children were judged as belonging in this group during the two subsequent years and, by the third year of the study, only four children out of a total sample of 45 were seen as still belonging in group 1.

Table 1. Distribution of the Groupings for the Three-Year Period*

	Initial Study		First Follow-Up		Second Follow-Up	
	Number of Children	Proportion	Number of Children	Proportion	Number of Children	Proportion
Group 1	10	.19	8	.17	4	.09
Group 2	25	.48	17	.37	16	.36
Group 3	17	.33	20	.43	23	.51
Group 4	0	.0	1	.02	2	.04
Total	52	1.00	46	.99	45	1.00

*The number of children decreases from one year to the next because some children dropped out of the study

There was a gradual decrease over the three years in the number of children who were judged as maintaining developmental progression (groups 1 and 2), along with an increase in the proportion judged as having their progression in development interfered with (group 3). Combining groups 1 and 2, so as to include all children who continued to show developmental progression (without or with accompanying pathology), we obtained a total of only two-thirds of the children in the first year of the study. For the next year, the majority of the children were still judged as maintaining developmental progression, although the proportion was less than it had been in the first year. By the third year of data-gathering, however, only a minority of the children were judged as belonging in this category(arrived at by

combining groups 1 and 2). (It should be noted that the proportions might have been even lower had we not excluded from the beginning those children who were schizophrenic, organically damaged, retarded or in therapy).

Stability of Groupings

For the majority of children, the group in which a child had been placed initially continued to be the group in which he was placed in the following two years (see Table 2). When there was a change in grouping a child, however, it was more often in a negative direction, reflecting the presence of pathology,[1] than in a positive direction.[2]

Table 2. Total Number of Changes in Groupings from One Year to the Next

	Total Number of Children	Children With No Change		Children With Change in Negative Direction		Children With Change in Positive Direction	
		Number-Proportion		Number-Proportion		Number-Proportion	
From first year to second year	46	35	.76	10	.22	1	.02
From second year to third year	45	31	.69	11	.24	3	.07

[1]Children judged as moving from group 1 to group 2 and from group 2 to group 3.

[2]Children judged as moving from group 2 to group 1 and from group 3 to group 4.

There was a tendency for the children to show either a continuation of or an increase in those disorders that interfere with development. There seemed to be a crystallization in the direction of more internalized deviations.

Discussion of Findings

The finding that such a large proportion of children were judged as having pathology with or without interference with development raises several questions. Our conception of developmental progression had included developmental crisis, developmental conflict and transient symptom formation. Nevertheless, we found a much higher incidence of pathology than is usually given in national statistics or reported in other investigations.[3]

In the section that follows we would like to explore some factors that may have contributed to this finding.

Developmental Expectations of Clinicians

Many members of our staff were, for the first time, studying a non-clinical population. Usually, a clinical view places emphasis on the dynamic factors in the formulation of symptoms, neurotic conflicts and adaptive processes. Moreover, the genetic approach highlights the impact of earlier childhood experiences and traumata on further development, and the lasting effect of minor disarrays on psychic function. In a clinical population, there is frequently the confirmation that disorders are found to be traceable to the first years of life. Because the

clinicians do not have sufficient experience with children who are functioning adequately despite certain psychic disorders, or with those whose conflicts have since disappeared, they may have a "clinical bias;" leading them to emphasize the significance of deviations in early childhood for later pathology. The judgment made may therefore be more in the nature of a prediction than an assessment of current developmental status.

The clinical orientation may also result in an incorrect assessment of various combinations of transient symptoms, developmental imbalances and conflicts, particularly since it is difficult to define the criteria that will permit us to separate various forms of conflict from transient symptoms and other developmental imbalances, and since we often find combinations of all these manifestations. This "clinical bias" may not only affect the diagnosis of children; it may also be expressed in the concept of "normal development." It could be that it was this that resulted in our looking for and emphasizing pathology--which may have contributed in part to our judging more children as belonging in groups 2 and 3 than in group 1.

Another possibility is that the reason why we placed an increasing proportion of the children in group 3 each year was that we were assessing them in terms of their deviation from some theoretical phase-expected development. That is, with the model of development we had in mind, we

may have expected a faster rate of development than is appropriate for the development of some children, or we may have expected changes in certain areas that did not take place with these children. A view that allowed for a slower rate of development might well have resulted in fewer children being placed in group 3.

Study Sample

Whether the predominance of children in groups 2 and 3 is related to the specific sample of children studied is another question.[1] As indicated above, this was a select population, coming from small, middle-class families with intellectually-oriented parents. These families often combine a permissive attitude toward the child with an

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[1]Because of this possibility, it was decided that our sample of non-clinical children should be enlarged and broadened to include a different socioeconomic and educational grouping; and, during the past two years, we have moved in that direction, studying children from working-class families with less well-educated parents. It will be of interest to see whether we come out with different groupings with these children, or perhaps find that their conflicts manifest themselves differently. In a parallel study of children from very low-income, deprived families, more severe pathology was found to exist than we found in our middle-class group of children, along with more frequent mixtures of organicity, under-stimulation and severe limitations in learning.

anxious concern about his development. As a consequence, children from these families may feel parental pressure that, more frequently than in other populations, results in conflicts and symptoms.

Thus, the possibility exists that the large proportion of children judged as showing pathology, with or without interference with development, is specific to this population. Yet even if our findings are, in fact, specific to this population, our study would still have significance; for children from small, middle-class families, with well-educated parents, do constitute a significant segment of our national population.

Environmental Expectations

It is possible that during this age period environmental expectations may contribute to the fact that an increasing proportion of children are judged as belonging in groups 2 and 3.[1] For example, the way in which some children are first separated from home, then moved into a nursery group setting, then moved to kindergarten in a new setting, and then again changed into first grade, with new teachers and perhaps new peers, may put more stress on a child than is developmentally appropriate. Or, the expectations of some teachers and parents may not sufficiently take into account the variety of conflicts and problems that a child may have to live through during these years, and that may

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[1]As a way of investigating the possibility that the increase in the number of children showing pathology and interference with development may be related specifically to this period of life, we have undertaken a follow-up study to assess this sample of children during the middle-childhood years, so as to see what happens at that time.

constitute a burden for, and an additional stress upon, the child. Furthermore, these undue expectations may have had their influence on the information some parents and teachers transmitted to us, resulting in reports that emphasized the limitations and difficulties experienced by the child.

Our study could not address itself to the relationship between various environmental factors and the groupings of the children. Further study might show whether children from each group have environments with certain specific features in common.

Reliability

There was 63 to 64 per cent inter-judge agreement each year between clinicians in their grouping of children. This can be compared to the 84 per cent agreement obtained when the same person made two assessments one year apart--that is, when the clinician who had done the data-gathering and had made an assessment then made a second assessment of the child, a year later, on the basis of reading his own process recordings.

The disagreements were of two types: the clinicians agreed on the psychodynamics operating in the child, but assigned different weights to specific data, which led to placing the child in different groups; or else they agreed on the appropriate grouping for a given child, but had different reasons for placing the child in that particular group.

There appeared to be several reasons for the lack of agreement in grouping. One reason was the emphasis placed by different clinicians on different aspects of psychic functioning. For example, some stressed ego adaptive processes, others, intrapsychic conflicts. The former tended to assess a larger number of children as being healthy, while the latter tended to assess more children as showing interference with development. Related to this, perhaps another reason for such disagreement was that those staff members who stressed ego adaptation grouped the child on the basis of behavioral data, while those who stressed intrapsychic conflict were more inclined to group the child on the basis of the psychodynamic meaning they themselves assigned to the behavior. In part, these disagreements may have been due to differences in training, personal bias or clinical experience with this age group.

The differences were clear between those children who were obviously progressing in development and therefore belonged in group 1, and those children who obviously showed interference with development and therefore belonged in group 3; everyone was able, with certainty, to place certain children in one or the other of these groups. It was more difficult, however, to decide between adjacent groups for some children--for example, when a child did show developmental progression, yet there was a decision to be made between group 1 and group 2; or when there was pathology, and the decision had to be made between group 2 and group 3. On the whole, it seemed easier to get agreement on whether or not pathology was present than on whether or not progression had been

interfered with in significant areas. (It was recognized that our system of grouping, like any system of grouping, was destined to be unfair to some children).

Whenever two clinicians did not agree on the grouping of a child, a third staff member was asked to study the total material, in order that we might have an additional judgment.

Implications of Findings

We now should like to consider some of the implications of our findings for theory, clinical practice, community health programs and early childhood education.

Interaction of Pathology and Development

Discussion about the frequency of disorders in early childhood may center around the decision to allow for pathological manifestations so long as progression is still being maintained. This, in turn, may depend on whether one assumes that these early deviations will have a significant effect on later development, or that intervention to modify these deviations could be considered from a clinical point of view.[1]

[1]Our groupings are based on the maintenance of or interference with developmental progression; we did not attempt to make any predictive statements, even when we found developmental interference during this stage of development. It is possible that, in some cases, there is an interference in development that can be corrected during later stages--latency, pre-adolescence or adolescence; but in our study we did not try to differentiate children among whom there is chronicity in the developmental fixation. One way to develop criteria for such differentiation is to follow these children over a long period of time. In the meantime, however, in the absence of such population studies of children, the clinician cannot postpone making a clinical diagnostic statement and a decision as to the indication for treatment.

At this stage, we are concerned about such a decision, particularly since we are attempting to outline primary and secondary preventive mental-health measures for children.

When the groupings on the basis of developmental progression were first set up, our proposal was for only three groups: progression in development has been maintained; progression in development has been interfered with in significant areas; progression in development had been interfered with in significant areas, but is again proceeding. When we tried to apply these groupings, however, it seemed that we were not able to do justice to some children, who did not fit into any of these groups. It therefore became necessary to add another group, namely: progression in development has been maintained, but with significant accompanying pathological features. Since this group of children raises many important questions, we are not ready to eliminate the group by attempting to put the children into either group 1 or group 3, for that would make it impossible to assess the effects of pathological manifestations on further development.

We had assumed that children go through successive stages according to a general timetable; furthermore, at each state, we expected to find a primacy of phase-specific organization, along with a disengagement of earlier psychic structure. When we find that the succeeding stage organization does not take place in accordance with the expected time-table, we assume that what we are dealing with is interference with

progression, fixation or regression. However, in the children who were judged as belonging in group 2 (children who showed pathological manifestations, but with the maintenance of developmental progression), there were indications of pathological functioning without interference with developmental progression. We found significant symptoms, adaptive problems, social conflicts, restrictions of emotional and intellectual function, and yet at the same time phase organization continued. There were many children for whom succeeding stages were reached while influences from earlier stages still remained operative; in other words, while there was progression, there was no concomitant disengagement of earlier psychic functioning. These children seemed to be able to show areas of functioning that permitted adaptation and socialization to take place, as well as progress in development, while they still maintained an inner conflict. Thus, we had to give recognition to the fact, that, despite pathological manifestations, there was no interference with development.

Symptoms and problems were thus found to be associated not only with interference in development, as in the group 3 children, but also with progression in development, as in the group 1 and group 2 children. We found that <u>every</u> child in this non-clinical population had some symptoms or problems. The differences in assessment of the children seemed to result from our looking at how each child coped with his conflicts. There could be a high degree of conflict-free development,

mastery, and positive functioning, even with a certain lack of resolution of conflicts. Perhaps future research and more intensive study of children such as those in our group 2 will determine to what extent there can be pathology while progression continues and adaptive functioning is maintained.

It is possible that, under certain circumstances, an interference with development may itself constitute an attempt to solve a conflict, or a regression may be an appropriate retreat within a specific environmental situation. These are questions for future investigation.

Developmental Model

There have been other studies, based on different models, with outcomes that, in part, confirm our findings. However, these other studies indicate a somewhat lower proportion than our study did of children with pathology with or without interference with development. Kellam and Schiff[4] carried out a study in which they asked first-grade teachers in 12 elementary schools to list ways in which children have difficulty adapting to the classroom. These statements by the teachers were sorted into five categories--social contact, authority acceptance, maturation, cognitive achievement, concentration--and each child was rated on a four-point scale for each of these, as well as on a sixth scale called "global adaptation." Approximately 30 per cent of the children were rated by their teachers as adapting on the global scale, while 70 per cent were seen as either mildly, moderately, or severely

maladapting.

In a study of "normal children and mothers" Harris[5] found that of a group of nine-and-ten year olds rated by their teachers as normal, only 25 per cent met his criteria of "optimum normality," i.e., well-adjusted in all facets of life at present and in the past.

Lois Murphy, in her study of coping behavior in children, defined coping as "the steps or sequences through which the child comes to terms with a challenge or makes use of an opportunity."[6] She notes that, like other investigations of "normal" children, her study found problems, symptoms and difficulties; only a minority of children in this "normal group" of her study had come through the sequence of critical phases with all their coping resources intact.

Our view of normal development assumed that each phase of development has its specific conflicts and conflict solutions, and that transient symptoms and infantile neurosis constitute part of the normal developmental process. Despite this, we judged many children as having had their progression interfered with in significant areas. Even combining groups 1 and 2, thereby including all children who showed progression in development, resulted in less than half the children being judged as showing "normal development" at the age of six years. We must, therefore, consider the possibility that clinical expectations, based upon psychoanalytic developmental propositions, may not adequately represent children's development in today's world, even though these

provide the bases for judgments that would be made if a child were taken to a clinic for diagnosis.

Our study suggests the need to re-assess our developmental model for the first six years of life, by looking at the balance between adaptive changeable forces and those constellations that maintain themselves despite developmental progression. The long-range effects of this interplay of development can be observed only by follow-up studies. Our assumption of what constitutes normal developmental progression may have to be revised further, so as to take into account the variety and the great frequency of conflicts, symptoms and developmental interference that we found to occur during this period. We are hesitant, however, to change the model without a great deal of further exploration, in order to avoid the possibility of adjusting the model to a "norm" by normalizing pathology. However, as we have stated in another paper,[7] this study would suggest the importance of recognizing many variations in development that may still be regarded as part of normal development.

Clinical Assessment

We may wonder whether grouping the children according to clinical diagnostic categories might have given us a distribution different from the one we found when we used developmental progression as a yardstick. It is our impression that it would not have been too different. The problem would then have been whether developmental conflicts or deviations--as compared with neurotic conflicts or character disorders, at this stage of development--can be differentiated from each other. We

believe that we would have found about the same proportion of children being judged as belonging to groupings outside the "normal" group.

Assessing children in terms of developmental progression, however, does have the advantage of exploring from a new point of view the possible implications of diagnosis and the indications for treatment.

It is significant that the assessment of a child between the ages of three and four provides indications about the child's developmental progression thus far, and the pathology that already exists, as well as the tendency toward chronicity. Thus, delay in assessing children during the first years of life, in order to await later development, is not justified if one is able to establish developmental groupings as early as three or four years.

Another implication has to do with the criteria for diagnosis. Our study confirms the clinical assumption that pathological evaluation, or the study of symptoms alone, may be misleading, insofar as the same clinical picture may have different meanings for different children, depending on its impact on further development. Thus, it is essential to determine <u>for each child assessed</u> the meaning of the observed pathology.

As to the indications for therapy, when we find a child placed in group 3 at the age of four, we would be inclined to initiate therapeutic intervention, on the assumption that the assessment of the child will not change significantly in the following years. However, there is still some question about the indication for treatment for children placed in

group 2 at this age, since some of these children will go toward group 1 in the following years, while others will go toward group 3. We must face the question, for a given child, whether to wait because development is progressing, or to select some method of therapeutic intervention that might contribute to the solution of the existing pathology.

Role of Education

As indicated above, most often the group in which the child was placed at the first data-gathering period was also the group in which he was placed in the next two years. This consistency in our assessment of the children had not been anticipated; rather we had assumed that there would be changes during the period between four and six years of age, as a consequence of the child's entrance into nursery-school, as well as of his continuing maturation. Before attempting to explore the implications of our findings for the field of education, it is important to look at those aspects of the child's personality that did indeed continue to develop, and also to consider the influence of the nursery-school on the child's functioning.

There is no question that the children in this study showed a capacity to expand their psychic and mental functions, in terms of such things as the movement from the family to nursery-school, the influence on the child of the socializing aspect of the school, the development of physical skills, and the increase in intellectual activities. This is in agreement with other studies, which have found pre-school programs

to be effective in raising intelligence scores, vocabulary level, expressive ability, and readiness for reading, as well as with studies that have found nursery-school experiences to be capable of contributing to a sense of mastery and power over the physical world, and to an increasing sense of security in that world.

In the past, it has been found that the children who benefit most from nursery-school are the ones who, when they begin school, are most open to the group experience, and most able to respond to the materials, the activities, the peer relations and relationships with non-family adults. In addition, however, when special attention is given to other, less "ready" children over a period of time, there is improvement, in the direction of their becoming more open to experiences.[1]

The findings of our study would suggest that there are wide ranges in the adaptive functioning of children between the ages of four and six years, and that, during these early years, different children function at different levels. Ego activities and defensive maneuverability showed that certain autonomous areas had not been affected by pathology. Had the study focussed on this area alone, a larger proportion of the children would have been judged as showing developmental progression. However, we found certain core constellations that we had

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[1]This would suggest the advisability of a more flexible educational program, which could be modified in the direction of: (1) individualizing programs in such a way as to contribute to optimal development; (2) preventing or minimizing the stress and strain that might otherwise contribute to the emergence of problems; and (3) attempting through educational means to deal with some kinds of problems.

been able to detect even at our first data-gathering, and which continued for the following years; in addition to the fact that the child was placed in the same group from one year to the next, there appeared to be a stability, over these years, in the clustering of psychic factors.

Despite the various expansions of ego-adaptive modalities, this core constellation was maintained. Thus, it would appear that one cannot expect the nursery-school experience in itself to have a specific effect on this clustering of psychic factors, nor should one expect it to undo conflicts and difficulties that are part of the expected developmental process.

Summary

This paper is based on the longitudinal study of the mental health or pathology of a non-clinical population of children, between the ages of four and six years, who were grouped in accordance with their developmental progression. We found that the majority of the children were seen as having pathology with or without interference with development, and that we were able, at age four, to detect basic psychic constellations that maintained themselves during the next two years.

Our findings substantiate other studies, which indicate that the first three years of life greatly affect the child's mental health function when viewed developmentally. Most recent studies, however, have referred to children who come from areas of economic, educational and cultural deprivation. By contrast, our study was carried out with

a population of children from an environment of economic, educational and cultural advantages. It appears to us, therefore, of great significance that our findings were similar, even though they were arrived at in connection with so different a group. Although the environment may be different, the functioning of the children may be different, and the diagnostic clinical picture may vary between these populations of children, what they have in common is the importance of the first years of life for subsequent development.

Our findings point up the necessity to develop means for assessing the mental health of children in the first years of life, as well as the necessity to explore the variety of mental-health services that may be desirable and useful for children between four and six years of age. We believe, however, that the findings of the present study need to be substantiated by further studies.

References

1. Flapan Dorothy, Neubauer Peter: Issues in assessing development. Accepted for publication by Journal of the American Academy of Child Psychiatry.

2. Bakan David: On Method. San Francisco, Jossey-Bass Inc, 1967.

3. Wall William D: Education and Mental Health. Paris, UNESCO, 1955; Clancy Norah, Smitter Faith: A study of emotionally disturbed children in Santa Barbara county schools. Calif. J. Educ. Res. 4:269, 1953; Wickman E.K.: Children's Behavior and Teachers' Attitudes. New York, Commonwealth Fund, 1928; Ullmann Charles A.: Teachers, peers and tests as predictions of adjustment. J. Educ. Psych. 48:257, 1957; Sommerset Survey: Great Britain, Ministry of Education: Report of the Committee on Maladjusted Children. London, England, Her Majesty's Stationery Office, 1955; LaPouse Rema: The epidemiology of behavior disorders in children. American Journal of Diseases of Children. Vol. III:594-599, June, 1966; Bower E.M.: Early Identification of Emotionally Handicapped Children in School. (2d. Ed.), Springfield, Illinois, Charles C. Thomas, 1969.

4. Kellam S.G., Schiff S.K.: A community-wide mental health program of prevention and early treatment in first grade. Psychiatric Research Report, 21. American Psychiatric Association, April, 1967.

5. Harris Irving D.: Normal Children and Mothers. New York, Free Press, 1959.

6. Murphy Lois: The Widening World of Childhood. New York, Basic Books Inc, 1962.

7. Flapan Dorothy, Neubauer Peter: Ibid.